No. _____

In The

Supreme Court of the United States

October Term, 1993

TRUSTEES OF THE WELFARE TRUST FUND, LOCAL UNION NO. 475, et al.,

Petitioners,

vs.

FRANCES J. DUNSTON, in her capacity as New Jersey Commissioner of Health, et al.,

Respondents.

Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

PETITION FOR WRIT OF CERTIORARI

WILLIAM F. MCENROE
Counsel of Record to Petitioners
PISARRI, MULLIGAN, MCENROE & CARERI
Attorneys for Petitioners
126 State Street
Hackensack, New Jersey 07601
(201) 342-3038

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTIONS PRESENTED FOR REVIEW

1. Is a State Act which requires ERISA employee benefit plans ("ERISA Plans") and their trustees to act in a manner inconsistent with their obligation under ERISA to apply fund assets for the exclusive benefit of Plan Participants preempted by ERISA as applied to ERISA Plans?

2. Is it permissible under ERISA for states to tap the funds of ERISA Plans in financing health care reforms as a means of making up budgetary shortfalls and avoiding unpopular new, general taxes?

3. Is it permissible for states to erode the protections afforded by ERISA and invade the assets of employee benefit plans by laws disguised as laws of "general applicability?"

4. Does a State Act which:

A. Imposes on ERISA Plans surcharges which are not indirect costs associated with any hospital service to Plan Participants but rather a direct cost of hospital services rendered to other patients;

B. Imposes upon ERISA Plan Participants, which comprise only about fifteen percent (15%) of hospital patients, almost forty (40%) percent of the state mandated cost shifts;

C. Requires ERISA Plans to subsidize the medical bills of others favored by the law;

QUESTIONS PRESENTED FOR REVIEW – Continued

D. Refers specifically to ERISA Plans and singles out ERISA Plans in requiring hospitals to ask patients whether they belong to a "Union Welfare Plan";

E. Expressly excludes "self-funded Union Plans" from appealing hospital bills;

F. Divests enormous sums of money from ERISA Plans; and

G. Is predicated on the existence of ERISA Plans,

have such an effect on employee benefit plans as to be preempted by ERISA?

5. Is the "police power" analysis of preemption employed by the majority below inconsistent with decisions of this Court?

PARTIES TO THE PROCEEDING

Trustees of the Welfare Trust Fund, Local Union No. 475 and Willie A. Barnes, John J. Parkin, Jr., Sydney Felix, Herman Geiger, Vinston Lee King, Kevin E. Kline, Robert L. Rosa, William Brennan, James Murphy, Jr., Patricia McElligott, Frank L. Harpster, Kevin McCormick, Patrick Ryan, Jr., Richard Caufield, Anthony E. Smith, Robert Laveratt, John S. Wittek, John McQuilken, Christopher Shields, John Montesano, Roy E. Frank, John O'Neill, Jr., Frank Robinson, Dale Schaefer, Ralph Sibona, Robert D. Stevely, John J. Serra, Donald Sheridan, Wenceslao Soto, Michael J. Russo, Joseph P. Murphy, Jr., James M. Thrash, Gary R. Myers, Calvin R. Sutton, III, Ronald J. Zakarzewski, Frank Whitney, Sr., Ursula L. Myers, Jack Nachtigall, Lawrence Parkin, Edison Rodriguez, William Moran, Peter Byrne, Vincent Doffont, and Andrew Williams,

Plaintiffs,

Frances J. Dunston, in her capacity as New Jersey Commissioner of Health; New Jersey State Department of Health; New Jersey Hospital Rate Setting Commission, Administrator of the New Jersey Health Care Trust Fund; New Jersey Department of Human Services (Division) of Medical Assistance and Health Services; St. Michael's Medical Center, East Orange General Hospital; West Hudson Hospital; University of Medicine & Dentistry; Overlook Hospital; Morristown Memorial Hospital; Union Hospital; Riverview Medical Center; Northern Ocean Hospital System; Community Medical Center; The Hospital Center at Orange; Hunterdon Medical Center; St. Clares/Riverside Medical Center; Warren Hospital;

PARTIES TO THE PROCEEDING – Continued

Centrastate Medical Center; Somerset Medical Center; Robert Wood Johnson University Hospital; Zurbrugg Medical Center; The Mountainside Hospital; The Medical Center of Ocean County; Jersey Shore Medical Center; Columbus Hospital; John F. Kennedy Medical Center; Clara Maass Medical Center, and Elizabeth General Medical Center,

Defendants.

In addition to the foregoing parties, all parties to the consolidated proceeding in the Court of Appeals are listed in the caption of the Opinion of the Court of Appeals which is reproduced in the Appendix. (1a-16a)[1]

CORPORATE DESIGNATION OF PETITIONERS

In accordance with Rule 29.1, Petitioners state that they have no corporate parent, subsidiary or affiliate.

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[1] Petitioners rely upon and reference the separate bound Appendix filed by the Petitioners in *NYSA-ILA Welfare Fund, etc. v. Frances J. Dunston, etc., et al.*, No. 93-115. References are to the pages of such Appendix.

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Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

PETITION FOR WRIT OF CERTIORARI

Trustees of the Welfare Trust Fund, Local Union No. 475, et al., Petitioners herein, respectfully pray that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Third Circuit entered on May 14, 1993.

OPINIONS BELOW

The Judgment and Opinion of the Court of Appeals for the Third Circuit, which is unofficially reported at 61

U.S.L.W. 2723 (3rd Cir. May 14, 1993), are reproduced in the separately bound Appendix in Case No. 93-115 (1a-61a). The unreported Opinion and Order of the Court of Appeals Sur Petition for Rehearing *en banc* (62a-63a), and the Opinion and Order of the United States District Court for the District of New Jersey (64a-95a), which is reported at 793 F.Supp. 524 (D.N.J. 1992), are also reproduced in the Appendix.

STATEMENT OF JURISDICTION

The jurisdiction of this Court is invoked pursuant to 28 U.S.C. §1254(1). The Judgment of the Court of Appeals for the Third Circuit was entered on May 14, 1993. Thereafter, the Court of Appeals denied a Petition for Rehearing by Order dated June 15, 1993. By Order dated July 8, 1993, entry of the mandate of the Third Circuit was stayed until July 22, 1993, pending the filing of a Petition for a Writ of Certiorari to the Supreme Court. By Order dated July 16, 1993, the stay was continued until August 6, 1993. This Petition is filed within ninety (90) days of the entry both of the Judgment of the Court of Appeals on May 14, 1993 and the denial of the Petition for Rehearing on June 15, 1993.

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

1. The Supremacy Clause of the United States Constitution, Article VI, Clause 2, provides that:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

2. The relevent provision from the Employee Retirement Income Security Act of 1974, as amended, ("ERISA") is §514(a), 29 U.S.C. §1144(a) (1988), which provides that:

> (a) Supersedure; effective date.
>
> Except as provided in subsection (b) of this section, the provisions of this Subchapter and Subchapter III of this Chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

STATEMENT OF THE CASE

BACKGROUND OF SUIT

The Complaint herein (the "Complaint") was filed by the Trustees of the Steamfitters Welfare Fund Local Union No. 475 of Warren, New Jersey (the "Welfare Fund") and individual participants in the Welfare Fund (the "Participants") in the United States District Court for the District of New Jersey on February 3, 1992 under Civil No. 92-426(AMW). By Order dated May 12, 1992, the matter

was consolidated for all purposes with all other cases previously consolidated in the "United Wire" case, Civil No. 90-2639.[2]

The Complaint sought, *inter alia*, judgment for declaratory and injunctive relief declaring, pursuant to 28 U.S.C. §2201, that certain portions of the New Jersey Health Care Facilities Planning Act of 1971, as amended and supplemented by the Health Care Cost Reduction Act of 1978, N.J.S.A. 26:2H-1 et seq. (the "Act"), together with certain of the regulations promulgated thereunder (N.J.A.C. 8:31B-2.1 et seq.) were null, void and of no effect under the Supremacy Clause of Article VI of the United States Constitution, and that such provisions were in conflict with and preempted by the United States Constitution, the Labor of Management Relations Act of 1947 ("Taft-Hartley" or "LMRA"), 29 U.S.C. §141 et seq., and particularly 29 U.S.C. §186(c)(5), as well as the Employment Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1001 et seq., and more particularly, 29 U.S.C. §1144(a). The Complaint further sought a declaration that such provisions violated the Equal Protection and Due Process Clauses of both the United States and New Jersey State Constitutions, constituted an illegal "special law" concerning taxation and an illegal delegation of taxing power under the New Jersey State Constitution. During the pendency of this action, the Welfare Fund has placed the disputed portion of each Participant's bill into an escrow fund.

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[2] The plaintiffs in the consolidated cases are referred to as the "Welfare Funds."

A. Plaintiffs

The Welfare Fund was established pursuant to the terms of the Collective Bargaining Agreement between Steamfitter, Pipefitters and Apprentices Local Union No. 475 ("Local No. 475") and the Mechanical Contractors Association of New Jersey (the "Association"). The Welfare Fund was established pursuant to and in accordance with the requirements of §302 of LMRA, 29 U.S.C. §186. It constitutes an employee benefit plan established and maintained by employers engaged in commerce and by an employee organization representing employees engaged in commerce in an industry and activity affecting commerce within the meaning of 29 U.S.C. §1003(a). It further is an employee benefit plan within the meaning of 29 U.S.C. §1002, supported by employer contributions pursuant to collective bargaining agreements and administered by a joint board of union and employer trustees for the benefit of collective bargaining unit members (the "Participants").

The Welfare Fund is a non-profit plan, self-insured and self-funded exclusively through employer contributions and not by way of outside insurance carriers, and provides its beneficiaries with a comprehensive health care program and retirement health benefits. The Welfare Fund is mandated by 29 U.S.C. §§186 and 1002 to expend funds only for the benefit of the Participants.

B. Defendants

The State Defendants[3] are charged under the Act with the administration or implementation of the hospital billing scheme established by the Act and regulations thereunder. Each of the Defendant Hospitals is required by N.J.S.A. 26:2H-18 to charge "payors" and patients in accordance with the schedule of rates approved by the State. All hospitals in New Jersey are classified as "health care facilities" which must obtain licenses in order to operate and must comply with rate procedures and schedules established by the Act.

C. Proceedings in District Court

After the filing of the Complaint and consolidation, the State Defendants and intervenor defendant, New Jersey Hospital Association (the "Hospital Association") moved to dismiss the Complaints pursuant to R. 12(c), Fed. R. Civ. P., and the various Welfare Funds cross-moved for summary judgment.

On May 27, 1992, District Judge Alfred M. Wolin granted summary judgment in favor of the Welfare Funds declaring that several aspects of the New Jersey Hospital billing scheme were pre-empted by ERISA. *United Wire, Health and Welfare Fund v. Morristown*, 793 F.Supp. 524

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[3] Frances J. Dunston, in her capacity as New Jersey Commissioner of Health; New Jersey State Department of Health; New Jersey Hospital Rate Setting Commission; Administrator of the New Jersey Health Care Trust Fund; and New Jersey Department of Human Services, Division of Medical Assistance and Health Services.

(D.N.J. 1992). The Court granted permanent injunctive relief barring the prospective enforcement of the challenged statutory regulatory provisions (94a), but, in order to allow the State an opportunity to file an expedited appeal and to seek a stay pending appeal from the Third Circuit, the Court *sua sponte*, stayed its injunction until June 5, 1992 (94a).

D. Appeal by Defendants

On June 17, 1992, the Hospital Association along with various individual defendant hospitals filed a notice of appeal. The State filed a notice of appeal shortly thereafter. By Order dated June 24, 1992, the Third Circuit granted a stay pending appeal and expedited the briefing schedule. On or about June 25, 1992, the Welfare Funds filed notices of cross appeal challenging the District Court's refusal to exercise jurisdiction over the claims for reimbursement of hospital bills paid under protest during the pendency of the lawsuit.

E. Third Circuit Decision

In a two to one decision announced on May 14, 1993, a panel of the United States Court of Appeals for the Third Circuit reversed the decision of Judge Wolin.

F. Petitions for Rehearing

Approximately five separate Petitions for Rehearing were filed on behalf of the Welfare Funds. On June 15, 1993, the Petitions for Rehearing were denied with a notation that Judge Nygaard, who had dissented in the

original decision, would have granted the Petitions for Rehearing. Motions thereafter were filed on behalf of the Welfare Funds seeking to stay issuance of the mandate. By Orders dated July 8, 1993, issuance of the certified judgment in lieu of formal mandate was stayed until July 22, 1993. On July 16, 1993, Orders were entered further staying the issuance of the certified judgment until August 6, 1993.

THE CHALLENGED DRG SYSTEM FOR HOSPITAL BILLS

In the District Court, Judge Wolin found that:

> The gravamen of the Complaint focuses on charges included within the hospital billing procedure which are in excess of a patient's "actual hospital costs". These include: cost of care for the indigent, charges to pay a hospital's bad debts, subsidies for the Medicare Program, and fees to reimburse hospitals for discounts given by the hospitals to other types of benefit plans. 793 F.Supp. at 526 (65a).

A. Total Charges

Pursuant to the Act, patients in New Jersey hospitals receive bills that contain several different statements of hospital charges. Each bill contains a "Total Charges" amount which is calculated by totalling a line-by-line itemization of the cost of hospital services rendered to a given patient. The Total Charges reflect the charges incurred by each patient for the services provided to that patient, including routine overhead costs associated with

hospitalization. These charges are ***not*** the ones normally paid by insured patients.

B. DRG Amount Due

Each hospital bill also contains the "DRG Amount Due".[4] This DRG Amount Due is calculated by the hospitals in accordance with the DRG rate setting procedures established under the Act. The DRG rate is selected by the hospital based upon the categorization of a patient's condition and treatment into one of 742 categories of medical conditions as defined by the Hospital Rate Setting Commission (the "Commission") and the New Jersey Commissioner of Health (the "Comissioner"). Each DRG category is assigned a hospital specific dollar amount which the hospital is required to charge to "purchasers of hospital services" regardless of whether the actual medical costs incurred in treatment are above or below the DRG rate. See, N.J.S.A. 26:2H-18; N.J.A.C. 8:31B-3.42.

C. Stated Intent of DRG Rate

The DRG rate is designed to set a prospective rate of reimbursement for each hospital in advance of actual treatment which is a blend of statewide averages of hospital resources consumed and hospital specific resources consumed in treating particular illnesses. N.J.Stat. Ann. 26:2H-5B. The DRG Amount Due set forth on each hospital bill, therefore, is not related to the actual costs

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[4] DRG stands for "Diagnostic Related Groups."

incurred by the patient, but rather upon a weighted average of costs incurred in statewide and hospital specific care for a given condition.

SURCHARGES ON DRG RATE

Although originally intended to be simply a weighted average of expected medical costs for a given condition, the DRG Amount Due no longer is such. The weighted average component (the "DRG Base Cost") is the base cost upon which surcharges are added to arrive at the DRG rate. Surcharges or "add-ons" are included in the DRG rate to pay for uncompensated medical care, the Medicare shift and payor differentials granted to various payors.

A. Uncompensated Care Surcharge

To compensate hospitals for indigent patients and bad debts incurred, referred to as "uncompensated care," a surcharge is added onto the DRG Base Cost. N.J.A.C. 8:31-3.41 and 7.1. This surcharge presently adds 19.1% to a hospital bill to pay for mandated care to indigents and the poor. This uncompensated care add-on is collected by each hospital and forwarded to the New Jersey Healthcare Trust Fund, which Fund then redistributes the money to hospitals statewide based upon the amount of uncompensated care costs incurred by each individual hospital. In the *Report of the Governor's Commission on Healthcare Costs*, (the "Governor's Report") this add-on for uncompensated care was characterized as a tax-subsidized social program of providing care to the poor.

According to the Governor's Report, uncompensated care costs increased from $288,000,000 in 1983 to $700,000,000 in 1990. Under the Act, the bulk of the subsidy for uncompensated care is taken from the Welfare Funds rather than the general public.

B. Medicare Cost Shift Surcharge

Each hospital bill also includes a 7% add-on to compensate hospitals for the "Medicare Cost Shift", which forces hospital payors other than Medicare patients to underwrite the shortfall between the DRG rate and the rate of reimbursement from Medicare for Medicare patients.

C. Surcharges for Discounts to Other Payors

The third cost shifting mechanism under the DRG Rate System involves "payor differentials" or discounts in payment rates available to certain classes of payors who demonstrate "quantifiable economic benefit" to the healthcare system. N.J.S.A. 26:2H-18(b); N.J.A.C. 8:31B-3.39. Payors which receive these discounts include Blue Cross, Blue Shield and HMO's. Due to restrictions imposed by ERISA, the Welfare Funds must limit their enrollment and are thus prohibited from receiving this discount and none of the Welfare Funds have been granted such a discount. As a result of the discounts offered to certain payors, a surcharge is levied on the remaining payors to offset revenue losses generated by such discounts. The Welfare Funds, therefore, are required to pay higher fees in order to make up for the discounts offered to other payors.

EXCLUSION OF ERISA PLAN PARTICIPANTS FROM RIGHT TO APPEAL

Under the appeal mechanism promulgated by regulation under the Act, uninsured patients, but not insured patients or third party payors, may obtain relief from excessive DRG Charges. All "non-insured" patients whose DRG Amount Due exceeds their actual medical costs by greater than $250 (95% of all non-insured patients) can appeal their bill for a reduction to the Total Charges amount. Greater than 99% of all such appealed bills are reduced to the actual medical costs incurred by the patient. Because Participants in the Welfare Funds are not permitted to appeal, the Welfare Funds again subsidize the system by underwriting the lower payments made by uninsured patients.

BALLOONING OF HOSPITAL BILLS

The DRG Amount Due exceeds the Total Charges Amount in approximately 85% of all hospital bills. In 1991, the average DRG Amount Due on a New Jersey hospital bill was approximately 60% higher than the Total Charges rate. Due to the numerous surcharges, the DRG rate is inflated significantly above both the actual medical cost incurred (Total Charges) and above the average medical costs incurred for each DRG category assignment (DRG Base Cost). These add-ons are levied exclusively upon hospital patients, a class which comprises less than 25% of New Jersey's residents in a given year. ERISA Plan Participants constitute but fifteen percent (15%) of this class of hospital patients, yet bear the brunt of almost

forty percent (40%) of the cost shifts mandated by the Act under the DRG system.

BASIS FOR FEDERAL JURISDICTION

The District Court found that it had jurisdiction over the plaintiff's claims brought under the United States Constitution, ERISA and Taft-Hartley pursuant to 28 U.S.C. §1132. The District Court further found jurisdiction over the causes of action arising under the New Jersey Constitution under principles of pendent jurisdiction and supplemental jurisdiction, 28 U.S.C. §1367. Venue was proper under 28 U.S.C. §1391. Jurisdiction in the Third Circuit on both the appeal and cross appeal from the final judgment of the District Court was pursuant to 28 U.S.C. §1291.

ARGUMENT

I. THE ACT "RELATES TO" ERISA PLANS AND THUS IS PREEMPTED

A. PRELIMINARY STATEMENT

By a two to one majority, in an Opinion announced on May 14, 1993, a panel of the Third Circuit Court of Appeals reversed the Decision of District Court Judge Alfred M. Wolin (793 F.Supp. 524 (D.N.J.1992)) (64a) which had concluded that challenged portions of the New Jersey Health Care Facilities Planning Act of 1971, as amended by the Health Care Cost Reduction Act of

1978, N.J.S.A. 26:2H-1, et seq. (the "Act") were unconstitutional and preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, et seq., as amended ("ERISA"). This Petition is brought on behalf of the Welfare Trust Fund, Local Union No. 475 and individual Participants therein[5] seeking the granting of a Writ of Certiorari to the Third Circuit.

Goals of ERISA

ERISA is a comprehensive statute designed to promote the interest of employees and their beneficiaries in employee benefit plans. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). In order to accomplish one of its main objectives of elimination of state regulation of employee benefit plans, ERISA contains a broad preemption provision in §514(a), 29 U.S.C. §1144(a), which provides that:

> Except as provided in subsection (b) of this section, the provisions of this Subchapter and Subchapter III of this Chapter (ERISA) shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . .

29 U.S.C. §1144(a).

This Court consistently has determined that when, as here, Congress adopts a broadly worded preemption provision in a comprehensive statute, the task of discerning congressional intent is considerably simplified. *Ingersoll-*

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[5] Appellees in Third Circuit Case No. 92-5320 and plaintiffs in D.C. Civil No. 92-426.

Rand Co. v. McClendon, 498 U.S. 133, 138 (1990). In discussing the preemption provision in ERISA, which the Court has noted "is conspicuous for its breadth", *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990) and "virtually unique", *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1, 25 n. 26 (1983), the Supreme Court has held that "its deliberately expansive language was designed to establish pension plan regulation as exclusively a federal concern". *Ingersoll-Rand v. McClendon*, supra at 138. Any doubts about Congressional intent are dispelled by the legislative history:

> The bill that became ERISA originally contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected these provisions in favor of the present language, and indicated that the section's preemptive scope was as broad as its language.

Shaw v. Delta Air Lines, 463 U.S. 85, 98 (1983).

ERISA Preemption

The focus of any ERISA preemption analysis has traditionally been the issue of whether the state laws in question "relate to any employee benefit plan". 29 U.S.C. §1144(a). Guidelines established by this Court for such analysis include:

> A law *relates to* an employee benefit plan . . . if it has a connection with or reference to such a plan.

Shaw v. Delta Air Lines, Inc., supra at 96-97.

> Under this "broad common sense meaning," a State law may "relate to" a benefit plan, and thereby be pre-empted, even if the law is not specifically designated to affect such plans, or the effect is only indirect.

Pilot Life Ins. Co. v. DeDeaux, 481 U.S. 41, 47 (1987).

Preemption Analysis by Third Circuit

The majority below set forth essentially a two-pronged test for its pre-emption analysis:

> 1. A rule of law relates to an ERISA plan if it is specifically designed to affect employee benefit plans, if it singles out plans for special treatment, or if the rights or restrictions it creates are predicated on the existence of such a plan. (citations omitted) (25a).
>
> 2. A state rule of law may be preempted even though it has no direct nexus with ERISA plans if its effect is to dictate or restrict the choices of ERISA plans with regard to their benefits, structure, reporting and administration, or if allowing States to have such rules would impair the ability of a plan to function simultaneously in a number of States. (citations omitted) (26a).

After enunciating this test, the majority concluded that:

> 1. Because we are here dealing with a statute of general applicability that is designed to establish the prices to be paid for hospital services, which does not single out ERISA plans for special treatment, and which functions without regard to the existence of such plans, the cases which have cordoned off this area of preemption are inapplicable (25a);

> 2. We, too, have before us a generally applicable law which (1) is not intended to regulate the affairs of ERISA plans, (2) neither singles out such plans for special treatment nor predicates rights or obligations on the existence of an ERISA plan, and (3) does not have either the effect of dictating or restricting the manner in which ERISA plans structure or conduct their affairs or the effect of impairing their ability to operate simultaneously in more than one State (30a); and,
>
> 3. We are unwilling to attribute to Congress and §514 an intent to frustrate the efforts of a state, under its police power, to regulate health care costs (31a).

It is respectfully submitted that such findings ignore the facts of this case and misinterpret decisions of this Court in that:

1. The Act is not a statute of general applicability;

2. The Act, in fact, does single out ERISA Plans for special treatment;

3. The Act cannot function without regard to the existence of ERISA Plans;

4. The Act is intended to and does regulate the affairs of ERISA Plans;

5. The Act predicates rights or obligations on the existence of ERISA Plans;

6. The Act does have the effect of dictating or restricting the manner in which ERISA Plans structure or conduct their affairs and benefits;

7. The Act does have the effect of impairing the ability of ERISA Plans to operate simultaneously in more than one state;

8. While states under their police power can regulate health care costs, such regulations transgress the preemption by ERISA when the result is to establish for the states a conduit to the money held by Welfare Funds as a means of financing state social programs rather than imposing a general tax.

B. REASONS FOR ALLOWANCE OF WRIT

Granting of this Petition is appropriate on the following bases:

1. THERE ARE SPECIAL AND IMPORTANT REASONS FOR GRANTING THIS PETITION IN THAT THE COURT OF APPEALS HAS DECIDED AN IMPORTANT QUESTION OF FEDERAL LAW IN A WAY WHICH CONFLICTS WITH APPLICABLE DECISIONS OF THIS COURT AS WELL AS DECISIONS OF COURTS IN OTHER CIRCUITS.

2. THE MAJORITY IN THE THIRD CIRCUIT WRONGFULLY FOUND THAT THE ACT IN QUESTION IS A "GENERALLY APPLICABLE STATUTE" AND IGNORED ITS DIRECT RELATIONSHIP WITH AND SUBSTANTIAL EFFECT UPON EMPLOYEE BENEFIT PLANS.

3. REVIEW BY THIS COURT IS NECESSARY TO CORRECT A SITUATION WHICH, IF LEFT AS IS, WILL EMPOWER STATES, IN THE NAME OF HEALTH CARE REFORM, TO TAP EMPLOYEE BENEFIT FUNDS AS A

SOURCE FOR MAKING UP BUDGETARY SHORTFALLS AND AVOIDING UNPOPULAR, GENERAL TAXES TO PAY FOR SOCIAL PROGRAMS – A RESULT NEVER ENVISIONED BY CONGRESS.

4. THIS APPEAL PRESENTS A QUESTION OF EXCEPTIONAL IMPORTANCE DUE TO THE POTENTIAL FINANCIAL IMPACT OF THE DECISION ON ALL PARTIES.

The majority opinion below concedes that were the Act to require the ERISA Funds and their Trustees "to act in a manner inconsistent with their obligation under ERISA to apply fund assets only for the benefit of fund participants," the Act would of course be preempted as applied to the plans. It is submitted that this is precisely the case here. The granting of the Petition is appropriate.

C. LEGISLATIVE INTENT OF THE ACT DISCLOSES A SUBSTANTIAL, DIRECT IMPACT ON ERISA PLANS

The official, declared public policy of the Act is to "contain the rising costs of health care services, and to insure the financial solvency of hospitals". N.J.S.A. 26:2H-1. An analysis of the compatibility of the Act with ERISA, however, requires an inquiry beyond the "official, declared public policy" to the undeclared, actual intent and effects of the Act.

Offending features of the DRG system which prompted the finding of ERISA preemption by the District Court included the following:

1. The Act both forces the Benefit Plans to structure benefits in a particular manner and subjects the Benefit Plans to inconsistent regulations (80a). *United Wire, Health & Welfare Fund v. Morristown*, supra, at 535.

2. The charges included in the DRG rate for uncompensated care, the shortfall for Medicare, and the discounts granted to certain payors, force the Benefit Plans to incur costs for the benefit of others if the benefit plans provide benefits to cover total hospital costs (81a). *Ibid.*

3. In states in which hospital rates do not include costs for others, the Benefit Plans can abide by their express purposes. Hence, the plans are subjected to inconsistent regulations (81a). *Ibid.*

4. Because the purpose of the Benefit Plans and ERISA itself foreclosed the plans from paying DRG rates, the Participants in the plans lose any right to appeal the cost of their hospital bills (82a). *Ibid.*

5. By virtue of their status, the Benefit Plans cannot qualify for an open enrollment discount. Importantly, the Benefit Plans must subsidize the recipients of these discounts (82a). *Id.* at 536.

6. The disputed provisions affect the structure of the Benefit Plans themselves (82a). *Ibid.*

7. The offending provisions in Chapter 83 and the corresponding regulations . . . subject the Benefit Plans to "ongoing administrative hardship" (82a). *Ibid.*

In his dissent, Judge Nygaard also found that the Act "related to" employee benefit plans, and pointed to the following provisions and effects of the Act as warranting a finding of preemption:

1. The majority decision would give states free reign to spend and experiment with ERISA funds held in trust for the many workers who have labored long for their security (43a).

2. The Act includes three surcharge components for (a) uncompensated care and bad debts; (b) medicare cost shifts; and (c) costs related to discounts given to certain payor groups. Only hospital patients, not the general public, pay the three surcharge components incorporated into the DRG rate (34a).

3. ERISA Plan Participants comprise only about 15% of the hospital patients but pay about 40% of the more than $1.1 billion shortfall generated by the state-mandated cost shifts. The financial drain on ERISA funds has been enormous (37a).

4. The surcharges imposed on ERISA plans are not indirect costs associated with any hospital services to Plan Participants, they are the direct costs of hospital services rendered to other patients, which have been shifted to ERISA plans (42a).

5. Rather than spend its own general funds, New Jersey implemented a money transfer scheme where ERISA plans subsidize the medical bills of those who are favored by law. The Act provides a conduit for money from ERISA Plans to hospitals (35a).

6. ERISA Plans pay a critical role in the cost shifting mechanism of the Act to the point where without them it would fall apart. The structure of the legislative scheme

indicates in not-so-subtle ways that the New Jersey Legislature was well aware of the pivotal role ERISA plans would play (34a).

7. The state has conceded that the scheme is not "viable" without money from ERISA Plans as they "represent a major segment of the bill-paying public, to the point that it is impossible to devise a viable hospital rate setting scheme if that segment is excluded or exempted from the scheme" (35a).

8. The Act refers to or specially singles out ERISA plans in that it requires hospitals to ask patients whether they belong to a "union welfare plan" and it expressly excludes "self-funded union plans" from appealing hospital bills (36a).

9. An ERISA Plan, if it does not want to pay for the direct cost of services provided to non-beneficiaries, must "structure all its benefit payments in accordance with New Jersey (hospital rates), or adopt different payment formulae for employees inside and outside of the state" (39a).

10. Under the Act, the plans are in effect precluded from negotiating group rates because the Act takes away any incentive to negotiate when it prohibits hospitals from passing on to other patients any revenue shortfall caused by a digression from the DRG rates (43a).

11. There is a definite, palpable connection between the Act and ERISA plans in that New Jersey has asked ERISA plans to carry the brunt of the burden of keeping

hospitals financially afloat and, in fact, to largely subsidize New Jersey's venture into hospital price regulation (39a).

12. The Act refers specifically to ERISA plans, divests enormous sums of money from ERISA plans, and is predicated on the existence of ERISA plans. The financial impact and other causal effect on ERISA funds results in the conclusion that the connection between ERISA plans and the Act is not too tenuous, remote or peripheral (44a).

D. IMPROPER TAPPING OF ERISA FUNDS BY STATES DEMONSTRATES "NON-GENERAL APPLICABILITY" OF THE ACT

The dissent hit the issue squarely on the head when, in concluding, Judge Nygaard stated:

> I fear that the majority gives States free reign to spend and experiment with ERISA funds, held in trust for the many workers who have labored long for their security, in the noble pursuit of health care reform so long as states exercise a minimum degree of imagination by couching their statutes in 'generally applicable' terms.

(43a-44a). While portions of the Act may be couched in such "generally applicable" terms, the effects of the Act, and the surcharge provisions in particular, are far from general in application. ERISA plans are singled out.

In discussing the Second Circuit's Decision in *Rebaldo v. Cuomo*, 749 F. 2d 133 (2d Cir. 1984), the majority below addressed the concept of a "generally applicable" statute

which "makes no reference to, (and) functions irrespective of, the existence of an ERISA plan". *Id.* at 483 (29a) The majority went on to conclude that the Act was such a "generally applicable" law (30a).

While the majority's conclusion as to the Act being a "generally applicable" law may be warranted as to the Base Cost feature of the Act, the conclusion is totally unwarranted as to the surcharge or cost shifting aspects of the Act. In particular, the majority's conclusion ignores the following factors:

1. The Act results in additional 19.7% and 7% surcharges in uncompensated and medicare cost shifts, respectively, to commercial insurers and ERISA Plans. The surcharges are not equitably distributed to the general population, or to the state, or to even hospital users, but are placed squarely on the shoulders of commercial insurers and ERISA Plans;

2. The Act disproportionately impacts ERISA Plans which have paid the lion's share of caring for the uninsured. ERISA Plan participants comprise only about 15% of the hospital patients, but pay about 40% of the more than $1.1 billion shortfall generated by the state-mandated cost shifts;

3. The Act has an effect of dictating or restricting the choices of ERISA Plans with regard to their benefits;

4. The Act in effect precludes ERISA Plans from negotiating group rates;

5. The Act expressly excludes "self-funded union" plans from the right to appeal a correct but excessive

charge which appeal right is available to individual patients only.

A direct result of the decision will be to make it open season on ERISA funds as a means of easing states' budgetary crunches or avoiding unpopular, new general taxes so long as states merely couch their laws in "generally applicable" terms. New Jersey unquestionably viewed ERISA Plans as ripe for picking, and deliberately set upon a course of action designed to tap this source of money. The Act in its purpose and effect is far from a "generally applicable" law. It is a law directed squarely at ERISA Plans and their funds in a manner Congress never intended to permit.

It is almost inconceivable that upon examination of the true purposes and impacts of the Act that one could conclude, as did the majority, that the effect of the Act on employee benefits plans is "too tenuous, remote or peripheral". Such conclusion flies in the face of all of the factors cited above.

E. THE MAJORITY OPINION CONFLICTS WITH DECISIONS OF THE SUPREME COURT AND OTHER CIRCUITS

In its preemption analysis, the majority found as "the most helpful case in the present context" the Second Circuit's Decision in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984). While agreeing that a portion of the *Rebaldo* court's analysis was rejected by this Court in *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), the majority found the *Rebaldo* analysis relating to the "indirect economic impact" of a "state statute of general application"

as persuasive. The majority stated that it was unpersuaded by the recent opinion in *Travelers Insurance Co. v. Cuomo*, 813 F.Supp. 995 (S.D.N.Y. 1993) where the District Court found that *Rebaldo* had been abrogated by later Supreme Court cases, specifically *Ingersoll-Rand Co. v. McClendon*, supra, *FMC Corp. v. Holliday*, 498 U.S. 52 (1990); and *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

The Supreme Court in *Ingersoll-Rand* expressly rejected the argument which was accepted in *Rebaldo* that Section 514 of ERISA preempts only a state law which "purports to regulate . . . directly or indirectly, the terms and conditions of employee benefit plans." While recognizing the effect of *Ingersoll-Rand* on the vitality of the *Rebaldo* decision, the majority continued to rely upon the so-called "traditional state police power analysis" of *Rebaldo* which analysis has subsequently been rejected by the Second Circuit itself in *General Electric Co. v. New York State Dept. of Labor*, 891 F.2d 25 (2nd Cir. 1989). There, although the court was faced with a law which was a "generally applicable" statute involving an area of traditional state police power in the area of labor costs and working conditions, the Second Circuit found that the statute was preempted because of its indirect burden on ERISA plans in the form of increased costs as well as the administrative burden of additional record keeping. This "state police power" reasoning of the *Rebaldo* court was also rejected in *Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y. 1993) and *United States Health Services, Inc. v. Upstate Administrative Services*, 578 N.Y.S. 2d 801 (Sup. Ct. 1991).

The majority's reliance upon a decision which, at best, is of doubtful reliability calls upon this Court to resolve this issue.

F. SUMMARY

Although unquestionably couched in terms of general applicability, the purpose and effect of the Act is far from general. While in certain respects, the ERISA Plans stand on even ground with all hospital users, at no time are they treated the same as the general public in terms of financing the objects of the surcharges, i.e., (1) uncompensated care and bad debts; (2) medicare cost shifts; and (3) costs related to discounts given to other payor groups.

In other respects, the ERISA Plans together with commercial insurers are treated in a manner different than any other hospital user, i.e, (1) screening of patients to determine coverage by a commercial insurer or "union welfare plan"; and (2) denial of any right to appeal assignment of a DRG as excessive. In still another respect, the ERISA Plans are segregated even from the commercial insurers as to the ability to negotiate group rates or discounts.

A statutory scheme with such effects can in no way be considered to be "generally applicable" nor as having a minimal effect on ERISA plans. Clearly, moreover, the effects on ERISA Plans are not unintended by the state. When ERISA Plan Participants, who comprise only about 15% of the hospital patients, pay about 40% of the more than $1.1 billion shortfall generated by the state-mandated cost shifts, the Act is intended to regulate the affairs of ERISA plans by drawing upon employee benefit

funds which ERISA is designed to protect, rather than the state's general revenues or the public at large. Such discrepancy in treatment establishes that ERISA plans are singled out under the Act. The Act further has a direct and significant effect upon how ERISA plans structure their benefits. These factors together with the direct, enormous financial impact on ERISA plans lead to the inevitable conclusion that the Act "relates to" ERISA Plans and is preempted.

CONCLUSION

Based upon the foregoing it is respectfully submitted that the Court grant the within Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit.

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Respectfully submitted,

WILLIAM F. MCENROE
Counsel of Record to Petitioners
PISARRI, MULLIGAN, MCENROE & CARERI
Attorneys for Petitioners
126 State Street
Hackensack, New Jersey 07601
(201) 342-3038